Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID COST SHARING

JULY 1993

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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JULY 1993 OEI-03-91-01800

EXECUTIVE SUMMARY

PURPOSE

To (1) review State Medicaid cost sharing policies and (2) determine their impact on the program.

BACKGROUND

Medicaid is one of the fastest growing programs in Federal and State budgets. Total Medicaid expenditures grew from $72.1 billion in 1990 to $94.5 billion in 1991, an increase of 31 percent. As Medicaid costs continue to rise, Federal and State officials are searching for cost containment measures.

One of the fastest growing trends in corporate health care cost containment is greater beneficiary cost sharing. Cost sharing requires beneficiaries to pay a portion of their health care costs. State Medicaid programs have also increasingly been using cost sharing as a cost containment method. States not currently using cost sharing policies may begin to reexamine the issue since Medicaid now absorbs 14 cents of every State dollar spent.

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Children, HMO enrollees, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions, are exempt from cost sharing.

To examine States' cost sharing policies, we collected detailed information from State Medicaid directors. We also reviewed data collected by the Health Care Financing Administration's (HCFA) information systems.

FINDINGS

Twenty-seven States use cost sharing in their Medicaid programs.

Cost sharing programs save money.

States without cost sharing could save between $167 and $335 million annually (of which the Federal share would be $99 to $198 million) by applying cost sharing to just four services -- inpatient hospital, outpatient hospital, physician visits, and prescription drugs.

States with cost sharing do not report significant impacts on utilization of services or access to care.

Cost sharing States have not experienced excessive administrative, recipient, or provider burdens.

Federal requirements may hinder States from designing even more effective cost sharing programs.

RECOMMENDATION

We believe that implementing or expanding cost sharing programs would allow States to (1) reduce program expenditures; (2) maintain or increase eligible populations; (3) maintain or increase covered services; and/or (4) maintain or increase reimbursement rates.

As a result of these conclusions, we make the following recommendation.

The HCFA should promote the development of effective cost sharing programs by:

- allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts, and/or

- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

The HCFA might also consider funding evaluation projects which formally assess cost sharing programs and provide information on the most effective structure of such programs.

The HCFA should promote the use of cost sharing in States that do not currently have programs. The HCFA could choose to exercise its leadership in a number of ways. The HCFA could:

- encourage States to implement cost sharing by providing information about State experiences with cost sharing and offering technical assistance and clarification of Federal requirements, or

- seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing, or

- seek legislation to mandate cost sharing for all States.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Management and Budget commented on the draft report; the full text of their comments is in Appendix D. Neither agency concurred with our draft recommendation. We have made several changes in response to their suggestions. However, we believe that the available evidence supports cost-sharing as a viable cost saving mechanism for financially strapped State programs, and would have a less deleterious effect on Medicaid beneficiaries than poor payment rates to providers, or elimination of services or eligible groups.

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INTRODUCTION

PURPOSE

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BACKGROUND

Cost Sharing

Medicaid is one of the fastest growing programs in Federal and State budgets. Total Medicaid expenditures grew from $72.1 billion in 1990 to $94.5 billion in 1991, an increase of 31 percent.

As Medicaid costs continue to rise, Federal and State officials are searching for cost containment measures. One of the fastest growing trends in corporate health care cost containment is greater beneficiary cost sharing. Cost sharing requires beneficiaries to pay a portion of their health care costs. State Medicaid programs have also increasingly been using cost sharing as a cost containment method.

States not currently using cost sharing policies may begin to reexamine the issue since Medicaid now absorbs 14 cents of every State dollar spent. According to Raymond Scheppach, Executive Director of the National Governor's Association, as State budgets rise and "governors are becoming more reluctant to ask for tax increases, States are likely to cut more deeply into spending and perhaps impose new 'user fees' for specific programs."[1]

Federal Cost Sharing Legislation and Regulation

Section 1902(a)(14) of the Social Security Act allows Medicaid to impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Medicaid cost sharing legislation has changed since the original 1965 law. The largest change to date occurred under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The TEFRA expanded cost sharing options to allow both the medically and categorically needy to pay nominal fees for almost all services. The legislation precludes providers participating under the State plan from denying service due to an eligible recipient's inability to pay the cost sharing amount. However, the provision does not extinguish the recipient's liability for the amount.

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[1]Jim Luther, "States may be forced to cut spending more despite tax increases," The Baltimore Sun, October 30, 1991, 6A.

Section 1916 of the Social Security Act was added by TEFRA and exempts the following populations and services from cost sharing : children, HMO enrollees who are categorically needy, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions. In addition, specific types of cost sharing such as enrollment fees, premiums, or similar charges cannot be imposed upon the categorically needy.

The Medicaid cost sharing payment regulations outlined in 42 CFR Ch. IV sections 447.50-.59 establish minimum and maximum charges for enrollment fees and premiums based on families' gross monthly income. The maximum deductible, coinsurance, or copayment charge for institutional services cannot exceed 50 percent of the Medicaid agency's payment for the first day of service. For non-institutional services:

- deductibles may not exceed $2 per month per family per period of eligibility;
- coinsurance rates may not exceed 5 percent of the service payment; and
- maximum copayment chargeable to recipient for services is $.50 to $3.00, depending on the cost of the service.

Previous Cost Sharing Studies

The largest study to date on the effects of cost sharing was conducted by the Rand Corporation. The Health Insurance Experiment reviewed health care consumption by insured individuals at randomly assigned levels of cost sharing. Over 7,000 people were assigned coinsurance rates of 0, 25, 50 and 95 percent. The purpose was to determine the potential effects of cost sharing on service utilization and overall health status. The federally-sponsored study ran over several years in the 1970's and early 1980's.

The study found that patients with limited cost sharing used approximately one-third fewer medical services than patients receiving free care. Apart from better blood pressure control and corrected far vision, participants in free care did not have significantly better health outcomes than patients with cost sharing plans.[2]

In a review of California's 1972 cost sharing experiment, most Medi-Cal[3] beneficiaries thought that cost sharing had not affected their health care. However, 17 percent

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[2]Robert H. Brook, Robert H., John E.Ware, Jr., William H. Rogers, Emmet B. Keeler, Allyson R. Davies, Cathy A. Donald, George A. Goldberg, Kathleen N. Lohr, Patricia C. Masthay, and Joseph P. Newhouse, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," The New England Journal of Medicine Vol. 309 No. 23 (December 8, 1983): 1426-34.

[3]California's Medicaid program is called Medi-Cal.

thought it had reduced the care available to them. These 17 percent were for the most part in households with chronic or significant medical needs.[4]

A more recent study on Medicaid prescription drugs found that New Hampshire's monthly limit on prescriptions caused a 30 percent drop in the number of prescriptions filled. After the limit was rescinded and a $1.00 copayment was implemented, prescriptions increased to just below pre-limit levels.[5]

For a more inclusive list of cost sharing references see Appendix A.

METHODOLOGY

State Interviews

We conducted structured telephone interviews with State Medicaid Directors or their representatives. To facilitate data collection, information sheets were sent to all States that had cost sharing programs prior to the interview. We also asked States to provide us with written material on

- the types and amounts of cost sharing,
- reported cost projections and savings, and
- cost sharing program evaluations.

We interviewed officials in 49 States and the District of Columbia. State officials in California declined to be interviewed but did provide us with written material. Whenever possible, we have included California's information in our State statistics.

Although Arizona does not have fee for service reimbursement, it was included in our interviews. Under the Title XIX demonstration project, the Arizona Health Care Cost

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[4]Carl E. Hopkins, Milton I. Roemer, Donald M. Procter, Foline Gartside, James Lubitz, Gerald A. Gardner, and Marc Moser, "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part I. The Beneficiaries' Reactions," Medical Care Vol. XIII No. 7 (July 1975): 582-94.

[5]Stephen B. Soumerai, Jerry Avorn, Dennis Ross-Degnan, and Steven Gortmaker, "Payment Restrictions for Prescription Drugs Under Medicaid: Effects on Therapy, Cost, and Equity," The New England Journal of Medicine Vol. 317 No. 9 (August 27, 1987): 550-56.

Stephen B. Soumerai, Dennis Ross-Degnan, Jerry Avorn, Thomas J. McLaughlin, and Igor Choodnovskiy, "Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes," The New England Journal of Medicine Vol. 325 No. 15 (October 10, 1991): 1072-7.

Containment System provides care through organized health plans and capitated reimbursement. However, Arizona does allow cost sharing by the health plans for a limited number of services. Therefore, we requested information on their experiences with cost sharing.

Data Reports and Information Systems

The information collected from our State interviews was compared with the HCFA's new State Profile Data System (spDATA) for inaccuracies. We found a few discrepancies and informed HCFA's Medicaid Bureau about the differences. The errors were found to lie with the data system and not our State-reported data. They were caused by time lags on newly implemented policies or data input mistakes.

To project cost savings, we used service numbers supplied by States on 1991 Form HCFA-2082. The data is based on service claims paid by State Medicaid agencies in Fiscal Year 1991. See Appendix B for a detailed description of the cost savings projection.

FINDINGS

TWENTY-SEVEN STATES USE COST SHARING IN THEIR MEDICAID PROGRAMS.

Twenty-six States cited containing costs or reducing unnecessary utilization as the main reasons for implementing recipient cost sharing in their Medicaid programs. Several States implemented cost sharing to promote an active role for recipients in their health care. One State also mentioned that they use cost sharing to encourage participation in health maintenance organizations (HMO) since HMO enrolled Medicaid recipients are exempt from cost sharing. See Appendix C for a list of States with cost sharing.

States have been using cost sharing for more than two decades. Half (14 of 27) the States have implemented their programs incrementally over the years. Five States established programs in the early to mid 1970's. Most States began programs during the 1980's. Two States implemented cost sharing programs in 1992.

Of the 24 States not currently using cost sharing, almost half are now considering programs. In fact, New York plans to implement cost sharing in the early part of 1993. The main reason States are considering cost sharing is budgetary restraints.

The most frequently used form of cost sharing is copayments.

All States with cost sharing use copayments as the main mechanism for sharing costs with recipients. Copayments range from 50 cents to $3.00, with the exception of inpatient hospital copayments which range up to $50 per admission. Four States also use 2 or 5 percent coinsurance for certain services and one State recently implemented an inpatient hospital deductible of $100.

No States use enrollment fees or premiums for medically needy individuals as allowed by Federal law. Two States used premiums in the late 1970s but found them cumbersome to administer and discontinued their use. Both States recounted that local offices had difficulty administering the programs since premiums were based on recipient income. Since incomes changed monthly, the premiums had to be recalculated every month resulting in increased staff time and record keeping.

States automatically deduct cost sharing amounts from provider reimbursement.

All States[6] reduce provider reimbursement for eligible recipients and services regardless of whether the copayment is collected. The majority do not require

[6]Except Arizona, which takes copayment amounts into account when developing its capitation rates.

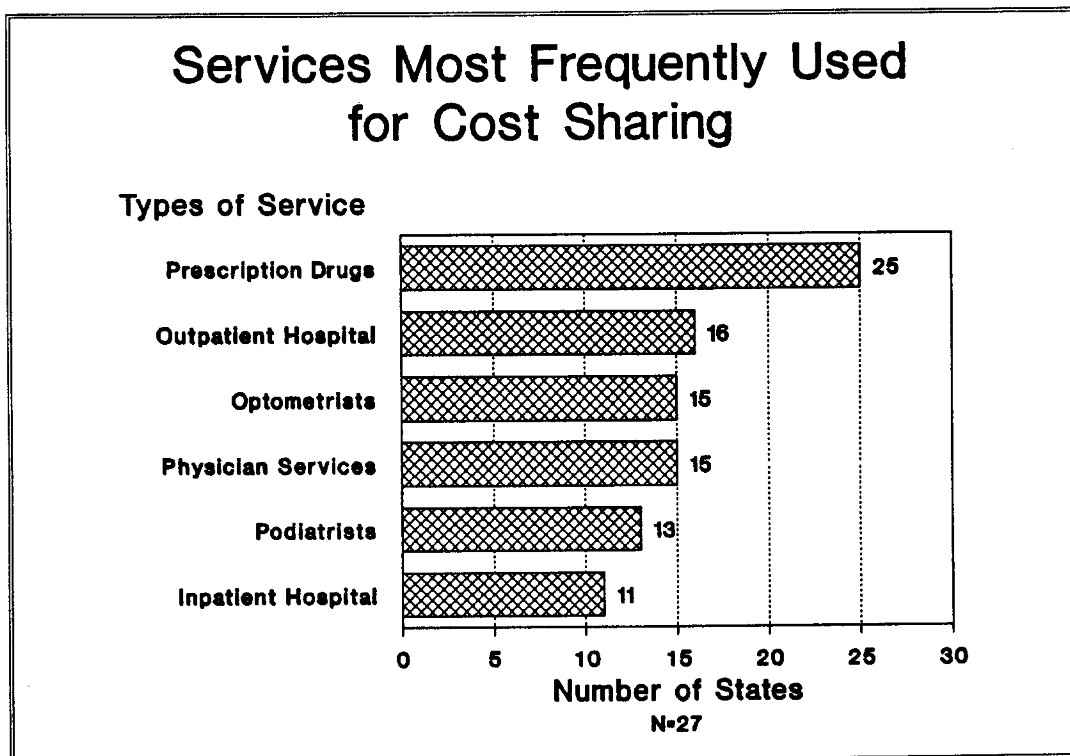
providers to indicate on the claim form whether they have collected or attempted to collect the cost sharing amount.

States use computer edits in their information systems and provider-supplied information to administer cost sharing. Computer edits match information from eligibility files to claim forms for exemptions such as children and nursing home residents. Edits also identify exempted services by diagnostic code, e.g. emergencies. Other States use exemption codes supplied by the provider to indicate emergency, family planning, or pregnancy services.

States apply cost sharing to both mandatory and optional Medicaid services with prescription drugs being the most frequent cost sharing service.

States apply cost sharing to a wide array of services. Some States have chosen to apply cost sharing only to mandatory services (States must provide these services as required by law); others apply it only to optional services (States elect whether or not to cover these services).

Most States apply cost sharing to both mandatory and optional services. Almost all States (25 of 27) employ cost sharing on prescription or pharmacy services. The services to which States most often apply cost sharing are shown below. A complete list of cost sharing services by State is presented in Appendix C.



The number of services with cost sharing varies among States. One State (PA) applies cost sharing to all but a few exempted services while five States apply

cost sharing to only one service. Two-thirds of States have more than five services with cost sharing.

States reported a number of rationales for selecting services for cost sharing. The most common was services for which States believed there was unnecessary utilization. Twenty-five percent said they wanted to put cost sharing on all the services allowed by Federal regulation. Several said they specifically chose services where they felt there would not be a negative impact on access. Other States mentioned choosing services where cost sharing would be easier to administer and collect. Finally, three States were given specific service choices from their State legislatures.

COST SHARING PROGRAMS SAVE MONEY.

Twenty-two of the 27 States reported that their programs reduced Medicaid expenditures.[7] Three States which had recently implemented programs had no information yet. One State which had no statistical proof of savings declined to respond.

Eleven States reported annual cost savings ranging from $325,000 to $9.5 million.

Of the 22 States reporting savings, 11 provided financial data. As shown below, eight States provided statistics from their information systems or outside evaluations and the remaining three were estimated dollars.

The three remaining States provided dollar estimates of $325,000, $500,000, and $2,250,000. These savings were attributed to cost sharing applied to prescription drug services.

State	Number of Services	Number of Recipients	Cost Savings	
Colorado	9	200,000	FY 1991	$2,168,342
Maine	10	147,886	FY 1992	$432,246[1]
Montana	26	70,000	FY 1991	$917,412
North Carolina	9	751,000	FY 1992	$5,518,910
Pennsylvania	all	1,177,161	FY 1990	$9,424,585
South Dakota	10	55,000	FY 1992	$708,384
Vermont	3	68,622	FY 1992	$906,199
Wisconsin	19	416,000	FY 1988	$6,700,000

[1] *Savings are for prescription drugs only and for the 11 month period 7/91-5/92.*

[7]California's written material did not provide us with cost savings information.

Of the eight States that provided actual cost savings, only Wisconsin included $2.1 million in savings from decreased utilization. The remaining seven States' savings figures represent only reductions in provider reimbursement by the amount of recipient cost sharing.

States without financial data believe cost sharing saves money.

The 11 States whose information systems did not collect savings information nevertheless believe their programs have achieved savings. Five States believe savings come from recipient cost sharing dollars and six believe savings come from a combination of cost sharing dollars and reduced utilization.

STATES WITHOUT COST SHARING COULD SAVE BETWEEN $167 AND $335 MILLION ANNUALLY BY APPLYING COST SHARING TO FOUR SERVICES.

Potential savings for 24 States without cost sharing depends on the number of eligible beneficiaries and services to which cost sharing is applied. However, we estimate that cost sharing on four services in these States could save the Medicaid program between $167 and $335 million a year. The Federal share could range from $99 to $198 million and the States could save between $68 to $137 million.

These savings are due to reductions in provider reimbursement alone and do not include savings from possible utilization changes. The savings would be even greater if States implemented cost sharing on more than just these four services.

This estimate includes four services -- prescription drugs, physician visits, inpatient hospital stays, and outpatient hospital visits. These services were selected because information on their use by recipients was available from State HCFA-2082 reports for 1991.

The number of services provided by each State without cost sharing was multiplied by the most frequently used copayment amount by States with cost sharing. The cost savings projection includes savings only from reductions in service reimbursement by the amount of recipient cost sharing and not reductions in service utilization.

The high estimate of $335 million is not reduced by the number of services that would be exempt according to Federal regulations. The $167 million estimate excludes these exempted services. See Appendix B for a more detailed description of the cost sharing projection.

STATES WITH COST SHARING DO NOT REPORT SIGNIFICANT IMPACTS ON UTILIZATION OF SERVICES OR ACCESS TO CARE.

Although 15 States cited reducing inappropriate utilization as one of the reasons for implementing cost sharing, States have not experienced significant reductions in the use of services after implementation of cost sharing.

Only three States have formally evaluated their cost sharing programs. Their results have differed, but in no case did they find a strong relationship between the implementation of cost sharing and significant reductions in the use of services.

The three States that have conducted formal evaluation are Wisconsin, California, and Montana.

Wisconsin's Office of Policy and Budget reviewed the State's cost sharing program in 1989.[8] Wisconsin looked at utilization information for cost sharing services implemented over several years. For a group of copayments implemented in 1981, they found a 1.5 percent decrease in utilization for services that were not greatly affected by other program changes (chiropractic, medical equipment and supplies, and transportation). For copayments instituted or increased in 1988, Wisconsin found a 1.5 percent drop in utilization for physician services and no decrease in outpatient hospital services. The Wisconsin report cautions that

> The utilization effect statistic must be interpreted with caution since factors other than copayments may account for this change, e.g., changes in provider participation. Probably the way to interpret the 1.5 utilization percentage is as the maximum that might be due to copayments.

In 1985, under contract with HCFA, California evaluated the Medi-Cal copayment demonstration project.[9] The evaluation found no significant changes in utilization for physician office visits, emergency room visits, physical therapy, chiropractic services, and optometry after copayments were implemented.

Montana's evaluation found that after copayments were implemented for 19 services, recipient usage increased for all services except 3 -- inpatient hospital, dental, and prescription drugs.[10] The reported decreases for inpatient hospital and dental services could not be attributed solely to copayment since there had also been changes in reimbursement methodologies and coverage. However, the 15 percent decrease in utilization from 3.17 prescriptions to 2.68 prescriptions per recipient may have been attributable to copayments.

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[8]Timothy Tyson, The Impact of Copayments on Medical Assistance Recipients: A Report to the Legislature (Wisconsin: Wisconsin Department of Health and Social Services, Office of Policy and Budget, Evaluation Section, June 1989).

[9]D. Jerome Hansen, James C. Cicconetti, Terri Stackpole, and John Keith, California Statewide Copayment Project (California: California Department of Health Services, July 1985), HCFA Contract No. 11-P-98206/9-03.

[10]KPMG Peat Marwick, State of Montana, Department of Social and Rehabilitation Services: Review of the Copayment Program, (November 1990).

than 2 percent of the calls to the Medicaid recipient hotline were about copayments in the 2 months preceding and the 4 months following copayment implementation. Most of these calls (95 percent) were questions and clarifications about cost sharing while 5 percent were complaints.

COST SHARING STATES HAVE NOT EXPERIENCED EXCESSIVE ADMINISTRATIVE, RECIPIENT, OR PROVIDER BURDENS.

Overall, States with cost sharing indicated they had few problems with implementation. Over 45 percent of States said they had no implementation problems. Other States mentioned working out concerns with advocacy groups and provider associations. Four States have had court cases brought against them by patient advocacy groups. All of these States have since implemented cost sharing.

Interestingly, more than half the States (15 of 24) without cost sharing believed it would be a financial burden for them to administer. They also felt cost sharing would impose too great a financial burden on recipients and providers.

The administrative expense is basically a one-time minimal cost for information system changes and information dissemination.

Five States furnished dollar estimates ranging from $2,000 to $100,000 for the information system changes. Two States estimated their staff time for rule-making and information dissemination at $15,000 and $30,000 respectively. The remaining States either could not break out the cost of their cost sharing program or estimated the cost to be "minimal" or "negligible."

New York, which is attempting to implement cost sharing, reported implementation cost of $1.5 million. Approximately $1 million was for client notification and $500,000 for information system changes including department and contractor costs.

The higher implementation costs are due to the large size of New York's program and the number of notices sent out due to court challenges and delays. However, if New York's initial cost savings projections are correct, New York should recover its expenditure in 1 month's time.

Some States reduce burden on recipients by expanding exemptions and capping cost sharing amounts.

Fifteen States have expanded the age of exempted children beyond the Federal requirement of 18 and under. Twelve States have expanded the age to 21, two increased to age 19, and one to age 20.

Fifteen States have expanded the pregnancy-related service exemption to include all pregnant women. Some States did this to alleviate administrative confusion, so that providers can exempt any woman who is pregnant. Otherwise, States require

providers to indicate that the service is pregnancy related, e.g., providers must write "related to pregnancy" on the prescription.

At least 12 States also exclude services to severely or chronically ill individuals. These include dialysis services, chemotherapy, radiation therapy, oxygen equipment, and home and community based services.

Five States have also tried to ensure that recipients are not overburdened by large cost sharing amounts by establishing caps on specific services or total cost sharing amounts.

- Colorado has a cost sharing cap of $150 per year.
- Maine established monthly caps for each cost sharing service that range from $4 to $30 per month.
- Montana allows cost sharing up to $127 per year for families. It also limits the cost sharing for inpatient hospital stays to $66 per admission.
- Pennsylvania caps copayments at $90 for a 6-month period. Inpatient hospital copayments may not exceed $21 per admission.
- Wisconsin caps inpatient hospital services, physician visits, and sole-provider pharmacy services at various dollars limits per year. Cost sharing for physical/occupational/speech therapy and psychotherapy ends after so many hours or dollars of service provided.

All States, except Pennsylvania, stop reducing provider payments when the dollar amount is reached. Pennsylvania rebates the amount paid over the limit to the recipient every 6 months.

Overall, among the 17 States that could estimate the number of recipients exempt from cost sharing, 9 States exempted between 40 and 50 percent and 8 exempted over 50 percent.

Provider responses to cost sharing are mixed. However, provider participation in Medicaid has not dropped due to cost sharing.

Over half the States reported little or no negative response from physicians when they implemented cost sharing. Several of these States said providers were used to cost sharing since it is a component of most third party health insurance.

Other States reported mixed responses, especially among different provider groups. Several States said specific provider groups in their State actually supported cost sharing by Medicaid recipients. Four States said provider groups were extremely opposed to cost sharing in the Medicaid program.

Provider complaints focused mainly on the administrative hassle attached to collecting cost sharing payments from recipients. Providers explain that if the amount is not collected at the time of service, the cost of billing for the amount exceeds the amount billed. Complaints were also received that providers looked at this as reducing reimbursement levels that they already consider too low.

Almost 90 percent of States (21 of 24) did not monitor collection of copayments by providers. Therefore, States don't know if recipients are making the payments. However, about one-third of the States believed that there are instances when cost sharing amounts are not being paid by recipient or collection is not being attempted by providers.

Although there is little State collected data on the impact of cost sharing on providers, provider surveys supply additional insight into the impact of cost sharing on physicians and their actions. The three State evaluations highlighted the following:

- Approximately 50 percent of all copayments went uncollected.
- Providers with high percentages of Medicaid patients were more likely to charge copayments.
- Providers felt the nominal nature of cost sharing amounts were not worth the billing or collection effort.
- Certain providers such as pharmacists more frequently collect cost sharing payments.

All except two States report no decreases in Medicaid provider participation after implementing cost sharing. One State has lost several podiatrists and they believe this might be due to a combination of copayments and declining reimbursement. Another State reported discontinuing a physician visit copayment after physicians threatened to drop out of the program. However, this same State characterized the pharmacy providers as being positive about the cost sharing program.

FEDERAL REQUIREMENTS MAY HINDER STATES FROM DESIGNING EVEN MORE EFFECTIVE COST SHARING PROGRAMS.

More than 40 percent of States with cost sharing voiced concerns about Federal cost sharing requirements. Seventy percent of these States felt that flexible Federal requirements would allow States to increase the effectiveness of their cost sharing programs. Several States also reported difficulty in preparing guidelines that allowed for effective cost sharing while maintaining compliance with Federal requirements.

States report that the Federal exemptions are too broad and the cost sharing amounts too nominal for certain services or eligible recipients.

Ten States with cost sharing responded that they would like to design more effective cost sharing programs. These States would increase cost sharing amounts or create exemptions targeted at specific vulnerable populations or services instead of broad exemption categories.

For example, States said they would increase coinsurance and copayment rates, include HMO enrollees in cost sharing, and waive certain exclusions for populations above a certain percentage of the poverty level. States speculated that this increased cost sharing would assist them in expanding eligibility to people not currently being served by their State's program.

States without cost sharing also indicated that Federal cost sharing regulations are a deterrent. Six States reported not implementing cost sharing because of restrictive Federal requirements.

States say defining a recipient's inability to pay cost sharing amounts is difficult.

Several States had difficulty in supplying guidelines to providers defining what constitutes a recipient's inability to pay for services. This is important since Federal law requires service to be provided even when a recipient is unable to pay the cost sharing amount at the time it is provided.

Most States do not have policies for handling recipients who are eligible for cost sharing but habitually do not pay. These States tell providers that verbal confirmation of inability to pay from recipients is proof of inability to pay. Only three States have outlined policies for their providers.

- Michigan's provider manual states that if the recipient fails to pay a copayment, the provider can, in the future, refuse to serve that recipient as a Medicaid patient.

- Pennsylvania advocates that providers cannot deny services because of recipient's inability to pay, unless there is "creditable evidence" that the recipient is able to pay, but refuses to do so. The policy states that a recipient found making purchases of non-essential items is an example of creditable evidence and requires the provider to document this in the record.

- Wyoming's guidance to providers states that since Medicaid copayment amounts are nominal, if a recipient regularly fails to pay the required copayment a provider may exclude the recipient from their practice.

The majority of States have not defined the difference between unwillingness to pay and inability to pay. States just refer providers to the Federal law stating that they cannot deny service but that the uncollected amount is considered a debt to providers.

RECOMMENDATIONS

The information in this report demonstrates that many States have developed cost sharing programs that reduce Medicaid expenditures. States have suggested that cost sharing allows Medicaid recipients to be a partner in their health care determinations. It also allows Medicaid recipients to become accustomed to an element common in private health insurance. States with cost sharing reported no evidence that cost sharing has a negative impact on recipients.

We believe that implementing or expanding cost sharing programs would allow States to:

- reduce program expenditures;
- maintain or increase eligible populations;
- maintain or increase covered services; and/or
- maintain or increase reimbursement rates.

As a result of these conclusions, we make the following recommendations.

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- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

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The HCFA should promote the use of cost sharing in States that do not currently have programs. The HCFA could choose to exercise its leadership in a number of ways. The HCFA could:

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- seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing, or

- seek legislation to mandate cost sharing for all States.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Management and Budget commented on the draft report. The full text of their comments is in Appendix D.

The Health Care Financing Administration Comments

The HCFA did not concur with our draft recommendation that the agency promote effective cost sharing in the States. The HCFA cited their desire to have cost sharing remain a voluntary State option. This desire is not inconsistent with our draft recommendation or our revised recommendations which appear in this final report. While mandating cost sharing is one approach that HCFA may choose to consider as a way to promote cost sharing, both in our draft report and in this final report we list other approaches which HCFA could use as well to accomplish this goal.

The HCFA agreed that there is sufficient evidence to show that cost sharing saves money for the Medicaid program. However, HCFA expressed concerns regarding the impact that cost sharing has on Medicaid recipients and providers of care.

We agree that the literature shows that certain vulnerable populations such as children, people with disabilities, and the chronically ill may be more adversely affected by cost sharing. And in this report, we outline some of the policies that States with cost sharing have implemented to protect these populations. These policies include capping cost sharing amounts, excluding certain services from cost sharing, and exempting children up to 21 years of age.

We also agree that cost sharing must be reviewed for its impact on providers. Although we found that cost sharing had not caused providers to leave the Medicaid program, we recognize that States with low provider participation must be concerned about recipients' access to providers.

In response to these concerns, we have decided to create two recommendations. The first addresses effectiveness of cost sharing programs and the second addresses the promotion of cost sharing in the Medicaid program. We believe that some of HCFA's concerns could be alleviated by allowing States to experiment with cost sharing programs. More flexibility would enable States to determine the needs of their individual program and populations and then develop a cost sharing program that fits those needs. States, for example, could choose to exempt specific vulnerable populations from cost sharing while targeting other populations like HMO enrollees for cost sharing.

The Assistant Secretary for Management and Budget Comments

The Assistant Secretary for Management and Budget believed that the sample size and data were insufficient to support the findings and that additional sample data needed to be collected before conclusions could be drawn on the effectiveness of cost sharing programs.

While we agree that only three States have formally evaluated their programs, testimonial evidence from 24 additional States confirms the evaluations' findings. We believe that taken together, this information provides strong enough evidence to support our findings. Certainly, we agree that additional research on cost sharing would be helpful; as a result, we have revised our recommendation to include the suggestion that HCFA direct some of its evaluation resources towards this end. In the meantime, however, we believe that the available evidence supports cost-sharing as a viable cost saving mechanism for financially strapped State programs, and would have a less deleterious effect on Medicaid beneficiaries than poor payment rates to providers, or elimination of services or eligible groups.

APPENDIX A

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APPENDIX B

COST SAVINGS ESTIMATE

Data Source

The data was taken from information reported to the Health Care Financing Administration (HCFA) by all States and the District of Columbia. The States report their data on the *Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services*, Form HCFA-2082. The data is based on claims paid for services provided in Fiscal Year 1991 (October 1, 1990 - September 30, 1991).

In the Annotations for the HCFA-2082 Data Tables, HCFA states that it does not guarantee the accuracy of the data provided by State Medicaid Agencies. However, HCFA does correct obvious errors and will estimate certain values when appropriate.

Savings Methodology

Of the service types available from the HCFA-2082 Data Tables, we selected services using two main criteria: (1) States frequently apply cost sharing to the service and (2) most of the services would not be exempted by Federal regulations. Utilizing this criteria, we selected three mandatory services and one optional service.

The three mandatory services include inpatient hospital, outpatient hospital, and physician visits. The optional service is prescription drugs. Although optional services vary by State, all States include prescription drugs as a covered service.

Whenever possible, we applied the most commonly used cost sharing amount when estimating our cost savings. For outpatient hospital, we selected $3 as the copayment amount since 8 of 16 States used it. For the remaining States, three other States used variable payments of $.50 to $3, 3 used $1, 1 used $2, and one had a coinsurance of 5 percent.

We selected $1.00 for physician visits. Out of 15 States using cost sharing on this service, 8 used $1, 3 varied between $.50 and $3, 2 used $2, 1 used $3, and 1 used $1 or $3 depending on the type of service. We chose $1 for prescription drugs also. For the 25 States applying cost sharing, 14 used $1, 8 used varying amounts from $.50 to $3, 2 used $.50, and 1 used $1.50.

For inpatient hospital services, we selected the most conservative cost sharing amount since States' methodology for applying cost sharing varies. Six of the States with cost sharing impose a one time copayment (or deductible for one State) per admission. Those payments range between $10 and $100 per hospital admission. Five State apply copayment charges on a per day basis. Three of the five States use a $3 cost share per day, one uses $5, and one varies between $2 and $3 depending on the cost of

service. After reviewing this information, we felt the most conservative choice would be a $3 copayment per total inpatient hospital days.

In order to estimate the cost savings to the Medicaid program if States without cost sharing implemented cost sharing on these four services, we extracted the number of paid service claims for the States without cost sharing. However, Rhode Island data was unavailable. Therefore, the cost savings estimates are based on 23 States without cost sharing.

We calculated the cost savings estimate in three steps. (1) The number of services for each State was multiplied by the cost sharing amount we selected. (2) Each State's service cost sharing amount was added to arrive at a total cost sharing amount. (3) The total service amounts for the four services were then added to project the total cost savings if States were to implement cost sharing on these four services. The numeric equations for this calculation follows:

STEP 1

$$S_i \times \$3.00 = ST_i$$
$$S_o \times \$3.00 = ST_o$$
$$S_p \times \$1.00 = ST_p$$
$$S_d \times \$1.00 = ST_d$$

STEP 2

$$ST_i^1 + ST_i^2 + ST_i^3 + \ldots ST_i^{23} = TAS_i$$
$$ST_o^1 + ST_o^2 + ST_o^3 + \ldots ST_o^{23} = TAS_o$$
$$ST_p^1 + ST_p^2 + ST_p^3 + \ldots ST_p^{23} = TAS_p$$
$$ST_d^1 + ST_d^2 + ST_d^3 + \ldots ST_d^{23} = TAS_d$$

STEP 3

$$TAS_i + TAS_o + TAS_p + TAS_d = \text{Total Cost Savings Estimate}$$

S = number of services
ST = each State's total cost sharing amount by service type
TAS = Total of all States' cost sharing amounts by service type
1-23 = Each number 1 through 23 equals one State's total
$_i$ = inpatient hospital days
$_o$ = outpatient hospital
$_p$ = physician visits
$_d$ = prescription drugs

We presented two dollar amounts for cost savings -- total cost sharing estimates with and without exempted populations. To estimate the number of services that would be excluded under Federal regulation, we used State reported data on exclusions.

States were asked how many of their recipients would be exempted from cost sharing. Out of the 17 States able to answer the question, 9 estimated 40 to 50 percent and 8 estimated over 50 percent.

Using this information, we selected 50 percent as the number of services to exclude for the exempted populations calculation. However we realize that the number of beneficiaries exempted may not equal the number of services exempted, since exempted populations may use a greater or lesser percentage of certain services.

Cost Savings Tables

The following four tables illustrate the cost savings calculations for each service type. The fifth table provides the total cost savings estimate with and without exemptions and the last table divides total savings into Federal and States shares.

Savings Calculation for Inpatient Hospital Days

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	53,417	$160,251	26,708	$80,124
Connecticut	379,891	$1,139,673	189,945	$569,835
Delaware	61,255	$183,765	30,627	$91,881
Georgia	1,069,789	$3,209,367	534,894	$1,604,682
Hawaii	70,456	$211,368	35,228	$105,684
Idaho	71,993	$215,979	35,996	$107,988
Indiana	609,076	$1,827,228	304,538	$913,614
Kentucky	593,995	$1,781,985	296,997	$890,991
Louisiana	694,894	$2,084,682	347,447	$1,042,341
Minnesota	361,285	$1,083,855	180,642	$541,926
Nebraska	117,623	$352,869	58,811	$176,433
Nevada	115,865	$347,595	57,932	$173,796
New Jersey	933,760	$2,801,280	466,880	$1,400,640
New Mexico	131,393	$394,179	65,696	$197,088
New York	4,473,440	$13,420,320	2,236,720	$6,710,160
North Dakota	55,068	$165,204	27,534	$82,602
Ohio	1,202,638	$3,607,914	601,319	$1,803,957
Oklahoma	195,918	$587,754	97,959	$293,877
Oregon	155,606	$466,818	77,803	$233,409
Rhode Island	NA	NA	NA	NA
Tennessee	754,690	$2,264,070	377,345	$1,132,035
Texas	1,599,687	$4,799,061	799,843	$2,399,529
Utah	96,990	$290,970	48,495	$145,485
Washington	406,366	$1,219,098	203,183	$609,549
Total	14,205,095	$42,615,285	7,102,542	$21,307,626

Savings Calculation for Outpatient Hospital Services

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	73,064	$219,192	36,532	$109,596
Connecticut	1,111,299	$3,333,897	555,649	$1,666,947
Delaware	892,655	$2,677,965	446,327	$1,338,981
Georgia	5,148,675	$15,446,025	2,574,337	$7,723,011
Hawaii	2,647,094	$7,941,282	1,323,547	$3,970,641
Idaho	37,470	$112,410	18,735	$56,205
Indiana	2,204,139	$6,612,417	1,102,069	$3,306,207
Kentucky	1,384,708	$4,154,124	692,354	$2,077,062
Louisiana	133,228	$399,684	66,614	$199,842
Minnesota	1,048,055	$3,144,165	524,027	$1,572,081
Nebraska	85,311	$255,933	42,655	$127,965
Nevada	203,386	$610,158	101,693	$305,079
New Jersey	995,812	$2,987,436	497,906	$1,493,718
New Mexico	72,110	$216,330	36,055	$108,165
New York	8,078,562	$24,235,686	4,039,281	$12,117,843
North Dakota	67,354	$202,062	33,677	$101,031
Ohio	2,440,571	$7,321,713	1,220,285	$3,660,855
Oklahoma	115,459	$346,377	57,729	$173,187
Oregon	92,043	$276,129	46,021	$138,063
Rhode Island	NA	NA	NA	NA
Tennessee	1,717,441	$5,152,323	858,720	$2,576,160
Texas	826,138	$2,478,414	413,069	$1,239,207
Utah	1,021,588	$3,064,764	510,794	$1,532,382
Washington	4,191,245	$12,573,735	2,095,622	$6,286,866
Total	34,587,407	$103,762,221	17,293,698	$51,881,094

Savings Calculation for Physician Visits

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	196,529	$196,529	98,264	$98,264
Connecticut	1,831,991	$1,831,991	915,995	$915,995
Delaware	377,440	$377,440	188,720	$188,720
Georgia	5,976,371	$5,976,371	2,988,185	$2,988,185

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Hawaii	4,967,763	$4,967,763	2,483,881	$2,483,881
Idaho	232,423	$232,423	116,211	$116,211
Indiana	1,542,287	$1,542,287	771,143	$771,143
Kentucky	2,383,344	$2,383,344	1,191,672	$1,191,672
Louisiana	9,151,352	$9,151,352	4,575,676	$4,575,676
Minnesota	2,292,306	$2,292,306	1,146,153	$1,146,153
Nebraska	917,483	$917,483	458,741	$458,741
Nevada	364,945	$364,945	182,472	$182,472
New Jersey	3,352,290	$3,352,290	1,676,145	$1,676,145
New Mexico	394,014	$394,014	197,007	$197,007
New York	6,470,838	$6,470,838	3,235,419	$3,235,419
North Dakota	472,104	$472,104	236,052	$236,052
Ohio	5,143,620	$5,143,620	2,571,810	$2,571,810
Oklahoma	740,794	$740,794	370,397	$370,397
Oregon	393,261	$393,261	196,630	$196,630
Rhode Island	NA	NA	NA	NA
Tennessee	4,065,459	$4,065,459	2,032,729	$2,032,729
Texas	9,627,597	$9,627,597	4,813,798	$4,813,798
Utah	1,666,551	$1,666,551	833,275	$833,275
Washington	3,651,570	$3,651,570	1,825,785	$1,825,785
Total	66,212,332	$66,212,332	33,106,160	$33,106,160

Savings Calculation for Prescription Drugs

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	299,039	$299,039	149,519	$149,519
Connecticut	3,449,149	$3,449,149	1,724,574	$1,724,574
Delaware	479,796	$479,796	239,898	$239,898
Georgia	8,841,481	$8,841,481	4,420,740	$4,420,740
Hawaii[1]	600,000	$600,000	300,000	$300,000
Idaho	750,107	$750,107	375,053	$375,053
Indiana	3,261,632	$3,261,632	1,630,816	$1,630,816
Kentucky	7,254,476	$7,254,476	3,627,238	$3,627,238
Louisiana	8,187,936	$8,187,936	4,093,968	$4,093,968
Minnesota	4,573,505	$4,573,505	2,286,752	$2,286,752

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Nebraska	1,979,626	$1,979,626	989,813	$989,813
Nevada	493,239	$493,239	246,619	$246,619
New Jersey	8,427,969	$8,427,969	4,213,984	$4,213,984
New Mexico	1,454,448	$1,454,448	727,224	$727,224
New York	26,168,221	$26,168,221	13,084,110	$13,084,110
North Dakota	607,885	$607,885	303,942	$303,942
Ohio	15,319,466	$15,319,466	7,659,733	$7,659,733
Oklahoma	2,373,168	$2,373,168	1,186,584	$1,186,584
Oregon	2,100,122	$2,100,122	1,050,061	$1,050,061
Rhode Island	NA	NA	NA	NA
Tennessee	8,239,598	$8,239,598	4,119,799	$4,119,799
Texas	11,474,997	$11,474,997	5,737,498	$5,737,498
Utah	1,253,431	$1,253,431	626,715	$626,715
Washington	5,270,693	$5,270,693	2,635,346	$2,635,346
Total	122,859,984	$122,859,984	61,429,986	$61,429,986

[1] *Since Hawaii provided number of pills instead of prescriptions, the 1991 prescription number was obtained from the National Pharmaceutical Council's Pharmaceutical Benefits Under State Medical Assistance Programs, September 1992, p. 77.*

Total Cost Savings Calculation

Types of Service	Savings without Exemptions	Savings with Exemptions
Inpatient Hospital Days	$42,615,285	$21,307,626
Outpatient Hospital Services	$103,762,221	$51,881,094
Physician Visits	$66,212,332	$33,106,160
Prescription Drugs	$122,859,984	$61,429,986
Total	$335,449,822	$167,724,866

Calculation for Federal and State Share of Savings

States	FMAP 1991[1]	Savings without Exemptions[2]	Federal Share[3]	State Share[4]	Savings with Exemptions[5]	Federal Share	State Share
AK	50.00	$875,011	$437,506	$437,505	$437,503	$218,752	$218,751
CT	50.00	$9,754,710	$4,877,355	$4,877,355	$4,877,351	$2,438,676	$2,438,675
DE	50.00	$3,718,966	$1,859,483	$1,859,483	$1,859,480	$929,740	$929,740
GA	61.34	$33,473,244	$20,532,488	$12,940,756	$16,736,618	$10,266,241	$6,470,377
HI	54.14	$13,720,413	$7,428,232	$6,292,181	$6,860,206	$3,714,116	$3,146,090
ID	73.65	$1,310,919	$965,492	$345,427	$655,457	$482,744	$172,713
IN	63.24	$13,243,564	$8,375,230	$4,868,334	$6,621,780	$4,187,614	$2,434,166
KY	72.96	$15,573,929	$11,362,739	$4,211,190	$7,786,963	$5,681,368	$2,105,595
LA	74.48	$19,823,654	$14,764,658	$5,058,996	$9,911,827	$7,382,329	$2,529,498
MN	53.43	$11,093,831	$5,927,434	$5,166,397	$5,546,912	$2,963,715	$2,583,197
NE	62.71	$3,505,911	$2,198,557	$1,307,354	$1,752,952	$1,099,276	$653,676
NV	50.00	$1,815,937	$907,969	$907,968	$907,966	$453,983	$453,983
NJ	50.00	$17,568,975	$8,784,488	$8,784,487	$8,784,487	$4,392,244	$4,392,243
NM	73.38	$2,458,971	$1,804,393	$654,578	$1,229,484	$902,195	$327,289
NY	50.00	$70,295,065	$35,147,533	$35,147,532	$35,147,532	$17,573,766	$17,573,766
ND	70.00	$1,447,255	$1,013,079	$434,176	$723,627	$506,539	$217,088
OH	59.93	$31,392,713	$18,813,653	$12,579,060	$15,696,355	$9,406,826	$6,289,529
OK	69.65	$4,048,093	$2,819,497	$1,228,596	$2,024,045	$1,409,747	$614,298
OR	63.50	$3,236,330	$2,055,070	$1,181,260	$1,618,163	$1,027,534	$590,629
RI	53.74	NA	NA	NA	NA	NA	NA
TN	68.57	$19,721,450	$13,522,998	$6,198,452	$9,860,723	$6,761,498	$3,099,225
TX	63.53	$28,380,069	$18,029,858	$10,350,211	$14,190,032	$9,014,927	$5,175,105
UT	74.89	$6,275,716	$4,699,884	$1,575,832	$3,137,857	$2,349,941	$787,916
WA	54.21	$22,715,096	$12,313,854	$10,401,242	$11,357,546	$6,156,926	$5,200,620
Total	———	$335,449,822	$198,641,450	$136,808,372	$167,724,866	$99,320,697	$68,404,169

[1] Federal Medical Assistance Percentage (FMAP) - Rate of Federal Financial Participation in a State's Medicaid Program for FY 1991.

[2] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming no recipients are exempted.

[3] The Federal share is arrived at by multiplying each State's total savings by the FMAP.

[4] The State share is arrived at by multiplying each State's total savings by (1 - FMAP), e.g. the calculation for Ohio would be savings multiplied by (1 - .5993) or .4007.

[5] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming 50 percent of the recipients are exempted.

APPENDIX C

COST SHARING ON MANDATORY SERVICES

State	Inpatient Hospital	Outpatient Hospital[1]	Physician Services[2]	Rural Health Clinic	Federally Qualified Health Center	Certified Nurse Practitioner
AL	50.00 a	3.00	1.00	1.00	1.00	1.00
AZ		5.00 n-e	1.00			
AR		.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
CA		1.00/5.00 n-e	1.00			
CO	15.00 a	3.00	2.00	2.00		
DC						
FL		1.00 n-e	1.00			
IL	2.00/3.00 d					
IA						
KS	25.00 a	1.00	1.00			
ME		.50-3.00				
MD						
MA		3.00 n-e				
MI						
MS	5.00 d	2.00	1.00	2.00	1.00	
MO	10.00 a	3.00[3]				
MT	3.00 d	1.00	1.00	1.00	1.00	
NH						
NC		3.00	3.00			
PA	3.00 d	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD		5 percent	2.00			
VT	50.00 a	3.00				
VA	100.00 a[4]	3.00	1.00/3.00			
WV						
WI	3.00 d	3.00	.50-3.00	2.00-3.00		.50-3.00
WY		3.00/3.00 n-e	1.00			
Total States	11	16 / 5 n-e	15	7	5	4

1 For ease of charting, we compressed non-emergency use of emergency room (n-e) with outpatient services.
2 Some States include specialized services, e.g., ophthalmology or medical psychotherapy, under physician services.
3 Includes 2.00 for outpatient service and 1.00 for physician service
4 Inpatient hospital deductible
a = cost sharing per inpatient hospital admission
d = cost sharing per inpatient hospital day

COST SHARING ON OPTIONAL SERVICES

State	Prescription Drugs	Optometric/ Optician/ Vision Services[1]	Podiatric Services	Dental Services or Treatment/ Oral Surgery[2]	Chiropractic Services	Durable Medical Equipment
AL	.50-3.00	1.00				3.00
AZ						
AR	.50-3.00	.50-3.00	.50-3.00			
CA	1.00	1.00	1.00	1.00	1.00	
CO	.50 g/2.00 b	2.00	2.00			
DC	.50					
FL	1.00	1.00	1.00	1.00 s	1.00	
IL						
IA	1.00	2.00/2.00 o	1.00	3.00	1.00	2.00
KS	1.00	2.00	1.00			3.00
ME	1.00 g/2.00 b		.50-2.00			.50-3.00
MD	1.00					
MA	.50					
MI	1.00	2.00	2.00	3.00 s	1.00	
MS	1.00			2.00		
MO	.50-2.00	.50-3.00	.50-3.00	.50-3.00		
MT	1.00	1.00	1.00	1.00		.50
NH	.50 g/1.00 b					
NC	1.00	2.00/2.00 o	1.00	3.00	1.00	
PA	1.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC	1.50					
SD	1.00			1.00	.50	5 percent
VT	1.00-2.00					
VA	1.00	1.00				
WV	.50-1.00					
WI	1.00	1.00	1.00-3.00	.50-3.00	.50/1.00	.50-3.00
WY	1.00	1.00				
Total States	25	15 / 2 o	13	9 / 2 s	8	8

1 For ease of charting, we compressed optometric/vision and optician services.
2 For ease of charting, we compressed dental services/treatment with oral surgery.
b = brand name
g = generic
o = optician services
s = oral surgery

COST SHARING ON OPTIONAL SERVICES

State	Psychiatry/ Psychology/ Psycho-therapy[1]	Audiology Services	Ambulance/ Transport Services	Eyeglasses	Medical Supplies	Prosthetic Device
AL					1.00	
AZ						
AR			.50-3.00			.50-3.00
CA	1.00	1.00				
CO	.50/15 min.					
DC				2.00		
FL						
IL						
IA	2.00	2.00	2.00		2.00	2.00
KS	2.00	3.00	1.00			3.00
ME		.50-2.00	.50-2.00		.50-3.00	
MD						
MA						
MI						
MS			2.00	2.00		
MO		.50-3.00		.50-3.00		.50-3.00 ae
MT	.50/1 hour	.50		1.00	.50	.50
NH						
NC				2.00		
PA	.50		.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD					1.00	5 percent
VT						
VA						
WV						
WI	.50-2.00	1.00	.50-3.00	.50-3.00	.50	
WY	1.00					
Total States	8	7	7	7	7	7

1 For ease of charting, we compressed psychiatric, psychological, and psychotherapy services.
ae = artificial eye

COST SHARING ON OPTIONAL SERVICES

State	Hearing Aids/ Hearing Aid Services	Home Health Services	Physical Therapy	Clinic Services	Dentures/ Denture Services	Occupational Therapy
AL						
AZ						
AR		2 percent				
CA			1.00	1.00		1.00
CO						
DC						
FL	5 percent				5 percent	
IL						
IA	3.00		1.00			
KS		2.00				
ME		.50-2.00	.50-2.00			.50-2.00
MD						
MA						
MI	3.00					
MS		2.00		1.00 s		
MO	.50-3.00				5 percent	
MT	.50	1.00	.50	1.00 d		.50
NH						
NC						
PA				.50-3.00	.50-3.00	
SC						
SD					3.00	
VT						
VA		3.00	3.00	1.00		3.00
WV						
WI	.50/1.00/3.00		1.00/30 min.		3.00	1.00/30 min.
WY						
Total States	6	6	6	5	5	5

s = State clinic
d = diagnostic clinic

COST SHARING ON OPTIONAL SERVICES

State	Speech Therapy	Ambulatory Surgical Centers	Community/ Mental Health Centers	Private Duty Nurse/ Personal Care	Other
AL		3.00			
AZ					a
AR				2 percent	
CA	1.00	1.00			b
CO			2.00		
DC					
FL					
IL					
IA					c,d/2.00
KS		3.00	2.00		d/3.00,e/3.00
ME	.50-2.00			.50-3.00	
MD					
MA					
MI					
MS					
MO					
MT	.50		1.00	.50	e/1.00,f
NH					
NC					
PA		.50-3.00			g
SC					
SD			5 percent		h
VT					
VA	3.00				
WV					
WI	1.00/30 min.				i
WY					
Total States	5	4	4	3	11

a = non-emergency surgery/5.00, diagnostic/rehabilitative x-ray and lab services/1.00
b = acupuncture/1.00
c = rehabilitation agency services/2.00
d = orthopedic shoes or orthotics
e = outpatient surgery
f = home dialysis/.50, free standing dialysis center/1.00, social worker/.50 per hour, licensed counselor/.50 per hour
g = diagnostic radiology/nuclear medicine/radiation therapy/medical diagnostic services (when billed in total or only technical component is billed)/1.00, all other covered services/.50-3.00
h = EPSDT screening/dental procedures/optometric, or optical procedures for those over age 18/1.00
i = Medical day treatment and assessment/.50 per day

APPENDIX D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 11 1993

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Medicaid Cost Sharing" (OEI-03-91-01800)

To Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the above-mentioned draft report which presents findings on the impact of State cost sharing policies on the Medicaid program.

The Health Care Financing Administration nonconcurs with the recommendation contained in the report. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.

Attachment

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Comments of the Health Care Financing Administration (HCFA) on
the Office of Inspector General (OIG) Draft Report:
Medicaid Cost Sharing, OEI-03-91-01800

Recommendation

The HCFA should promote the development of effective cost sharing programs within States.

(1) The HCFA could encourage States to implement cost sharing. The HCFA could accomplish this by:

- o providing the States with technical assistance and information about State experiences with cost sharing;
- o allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or
- o recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

(2) The HCFA could seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing.

(3) The HCFA could seek legislation to mandate cost sharing for all States.

Response

HCFA nonconcurs with this recommendation. We believe cost sharing should remain a voluntary State option.

The legislative history of section 1916 of the Social Security Act indicates that it was designed to allow States greater flexibility in the use of cost sharing without imposing unnecessary hardships on Medicaid recipients. Current regulations provide the States with a wide variety of options, and, thus, a considerable degree of program and administrative flexibility. Some of these options are as follows: (1) use of enrollment fees or premiums for the medically needy rather than copayments; (2) use of deductibles rather than copayments; (3) ability of States to relate recipient cost sharing to income (within maximum amount specified in regulations) and to charge different amounts to medically needy and categorically needy recipients; and (4) optional use of cumulative maximums for all deductibles, coinsurance, or

copayments charged to a family. While we agree that there is sufficient evidence to suggest that cost sharing saves money for the State Medicaid program and the Federal government, we believe that any changes in cost sharing policies should also be viewed in terms of its effect on Medicaid recipients.

There are significant variations of the Medicaid program among States. Consequently, advocating cost sharing may have differing effects on Medicaid recipients. Since States are looking at ways to decrease welfare payments, increased cost sharing may mean increased copayments for recipients who, in turn, will have even less money for other basic maintenance needs which have also risen in cost.

There are also potential difficulties with the implementation of cost sharing for outpatient prescription medications. One potential difficulty is that access to drugs may be limited, and the dollar savings on drugs may be outweighed by the use of high cost services, emergency rooms and potentially avoidable hospitalizations because of adverse complications experienced by persons who do not obtain their prescriptions. Any recommendation that includes prescription drugs should be reviewed to ensure that it does not conflict with other State options for limiting access to outpatient drugs for Medicaid, such as limits on the number of prescription transactions per month or on the supply (e.g., 30-day supply, 6-month supply), or a State's option to totally exclude certain drugs from reimbursement. These other limitations can also cause high-cost adverse health care needs. Furthermore, the added demand for a copayment, particularly if it is based on a percentage of total charge for the drug which is already high, can place an added burden on the Medicaid recipient.

Another consideration is the impact of cost sharing on providers of care for the Medicaid population. The burden for collection of "shared cost" is shifted to the provider. In some parts of the Medicaid program, provider reimbursement for care to Medicaid eligibles functions more as a disincentive than an incentive. The need for the provider to collect a copay from the Medicaid population may well function simply as another cap on provider fees rather than a true recipient share in the cost of medical care. Although OIG mentions that the burden is on the provider to collect the copay, this report would be enhanced by showing how copay is related to physician fees, especially the new HCFA physician fee schedule. For crossover patients covered by Medicare and Medicaid, the physician is subject to the Medicare physician fee schedule and the limits of State Medicaid program reimbursement rates. Cost sharing should not serve as a barrier to receiving necessary medical services. The question of whether providers deny medical care because of a failure to collect the patient's shared portion of cost is possibly important, but reportedly unknown to those in the State Medicaid offices.

Lastly, we believe that no further action should be taken pending the development and announcement of the Administration's health care proposal. However, if OIG decides to issue this report in final, we suggest that the report be shared with the States.

Technical Comments

The section of the report entitled, "Previous Cost Sharing Studies" could be improved by referencing the studies and adding caveats about the serious methodological flaws or shortcomings in them. We would not want them presented as useful testimony for current day practices or future program and policy recommendations.

In the Executive Summary Findings, the potential savings are shown as being between $167 to $335 million annually. We suggest adding a statement to explain that variance, e.g., ". . . . savings of $167 million under current law, and $335 million if existing exemptions for covered populations and services were to be legislatively repealed."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office of the Secretary

Washington, D.C. 20201

MAR 30 1993

MEMORANDUM TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM : Elizabeth M. James
Acting Assistant Secretary for
Management and Budget

SUBJECT : OIG Draft Report on Medicaid Cost Sharing
OEI-03-91-01820

Thank you for the opportunity to review this draft report. Focusing on the area of cost containment is important and the report obtained some good information through the executive interviews. We are, however, concerned with the conclusion that "the report demonstrates that States have developed cost sharing programs that reduce Medicaid expenditures."

We wish to raise two issues concerning your findings and the ensuing recommendations. First, the sample size and data are insufficient to support the findings. This conclusion is based on the following:

- Of the 27 states, only three provided program evaluation data (two of which were inconclusive).
- 22 states said that the cost sharing programs had reduced Medicaid expenditures. However, only 11 provided financial data depicting estimated savings.
- Only one of the state's estimates of savings included reductions in utilization. The remainder represented reductions in provider payments.
- The calculated savings estimates may be overly simplified. The maximum value was calculated simply by multiplying the number of 1991 claims by a "frequently used" copayment. A 50 percent exemption of services was assumed to arrive at the minimum value. **A 50 percent recipient exemption is not necessarily equal to a 50 percent service exemption.**

Second, the analyses of the sample data do not cover the interactions between cost sharing and other cost containment polices which could have influenced the observed Medicaid savings. For example,

- No analysis of changes in provider participation has been done. The only state with conclusive program evaluation data indicated that provider participation had remained stable not because recipients were paying the copayment but mainly because pursuit of the nominal amount was more expensive than the value of the copayment.

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- 17 states implemented other cost containment programs at the same time as their cost sharing and thus were unable to truly measure the effect of cost sharing.

- There is no attention to the burden incurred by recipients and providers from cost sharing programs. States are uncertain whether recipients are actually paying the copayments.

We believe additional sample data needs to be collected and analyzed before conclusions can be drawn as to the effectiveness of cost sharing programs. Perhaps a primary recommendation of this report should be that HCFA pursue further analysis in this area.